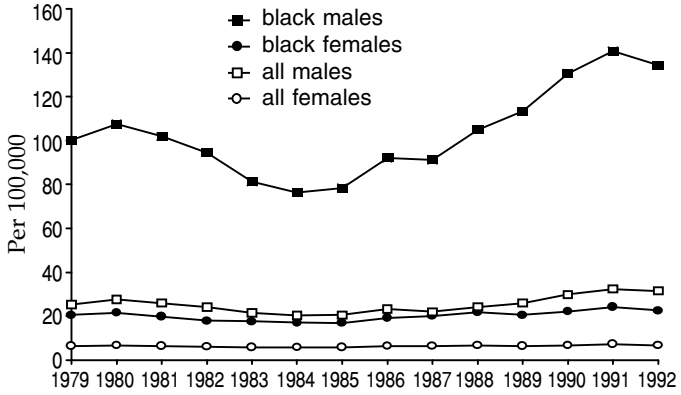
PROGRESS REPORT FOR: Black Americans

ON DECEMBER 14, 1994, the Public Health Service (PHS) conducted the first cross-cutting review of progress on HEALTHY PEOPLE 2000 objectives for black Americans. The Acting Deputy Assistant Secretary for Minority Health reviewed strategies and barriers toward achieving the year 2000 targets. Other PHS participants in the progress review included the Surgeon General, Deputy Assistant Secretary for Population Affairs, Director Designate of the National AIDS Policy Office, Director of the Centers for Disease Control and Prevention, Director of the National Cancer Institute, Director of the National Heart, Lung, and Blood Institute, and the Director of the Center for Substance Abuse Prevention. They were joined for the review by invited guests from the University of California at San Francisco, Jackson State University, Harlem Hospital Center, District of Columbia Coalition Against Drugs and Violence, District of Columbia Department of Corrections, and the Michigan Department of Health.

The 1990 Census reported nearly 30 million black Americans; at 12.3 percent of the population blacks represent the largest minority group. With respect to a number of health status indicators, however, the statistics for blacks have lagged behind the total population. Infant mortality is one example: black babies are twice as likely as white babies to die within their first year, with higher rates of low birthweight an important contributing factor. Although life expectancy has improved for all sectors of the population over the course of this century, it is still lower for blacks than for others. In 1992, life expectancy at birth for the total population reached a record high of 75.8 years. Life expectancy for selected population subgroups in 1992 was as follows: 73.2 years for white males, 65.0 years for black males, 79.8 years for white females, and 73.9 years for black females. Differences in health outcomes, however, may be due to a wide range of social, political, economic, and other factors.

HEALTHY PEOPLE 2000 includes 48 subobjectives for black Americans that are spread across 18 priority areas. Additionally, 37 new subobjectives have been added in the recent midcourse review. The discussion in this progress review focused on five topics of particular concern: violence, adolescent pregnancy, HIV/substance abuse, cancer, and heart disease. Objective 7.1 seeks to reduce homicides for black females and black males aged 15–34. Homicide death rates for these two groups, however, are moving away from the year 2000 targets. Between 1987 and 1992 the rate per 100,000 for 15–34-year-old black females increased from 20.2 to 22.7; during this same period the rate for 15–34-year-old black males increased from 91.1 to 134.2 (see figure above). By comparison, the homicide rate for all 15–34-year-old females increased from 6.5 to 6.8 and all 15–34-year-old males increased from 22.0 to 31.6 per 100,000. The discussion

Homicide Death Rates for Americans, 15–34 Years, 1979–1992



Source: CDC/NCHS, National Vital Statistics System, 1979-92

pointed out the need to view this problem as more than a law enforcement issue; the escalating rate of homicide is a public health crisis. There is a need for increased family and community involvement in intervention strategies as well as evaluation of ongoing research and programs. Among the approaches currently underway within the PHS are changing the physical environment, increasing public awareness, improving the social environment, and conflict resolution training.

Although data indicate that the pregnancy rate among adolescents 15–19 years of age has remained fairly steady, the more significant trend—pregnancy rates among sexually active teenagers—has declined in the last two decades. Much of this is attributed to increased contraceptive use, particularly condoms, among sexually active adolescents. Yet, pregnancy rates remain higher for black adolescents than for their white or Hispanic peers. Some 19 percent of all black women aged 15–19 become pregnant each year, compared with 13 percent of Hispanics and 8 percent of whites. The higher rate among black teens is probably due to the fact that they are less likely to use a contraceptive method or use it effectively.

Although we do not yet know what specific interventions are most successful in preventing adolescent pregnancy, efforts combining education and services have shown the most promise. Future interventions to address the high rate of adolescent pregnancy in the United States need to ensure access to comprehensive health education and services, reinforce more positive role models for young people, and overcome social reluctance to mainstream family planning and contraception for teenagers.

The need to include males in prevention programs was also highlighted, as was the link that exists between adolescent pregnancy and risk factors such as substance abuse, sexual abuse, poor school performance, drop out rates, violence, and poverty.

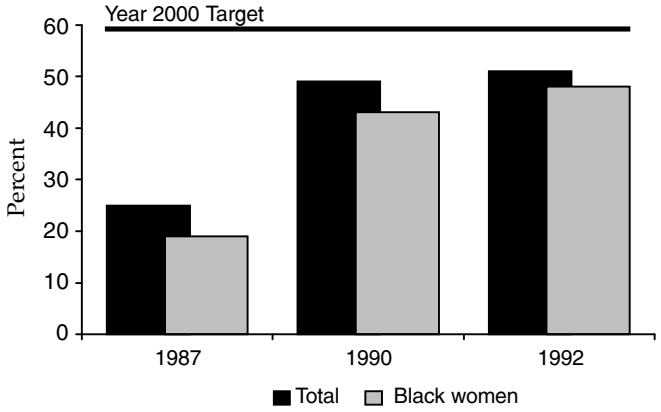
Black Americans continue to have relatively high rates for HIV infection/AIDS (objectives 18.1 and 18.2). In 1993, 58,538 cases of AIDS were reported among racial/ethnic minorities; of these, 66 percent were reported among blacks. The AIDS rate for black females was about 15 times their white counterparts, and the rate for black males was almost fives times that of white males. In 1991, among males aged 25–44, HIV infection was the leading cause of death for blacks. Among the barriers to prevention mentioned are that HIV/AIDS may not be viewed as among the highest priorities in some communities that have other life survival problems; programs need to be targeted appropriately, and often persons with HIV/AIDS do not have adequate health insurance and access to care.

Cancer is the second leading cause of death for blacks, with a higher age-adjusted death rate than any other racial group. Between 1973 and 1991, cancer mortality for white males increased by 5.6 percent while it increased by 23.6 percent for black males. For females, the rate of cancer mortalilty increased 13.3 percent for blacks and 8.1 percent for whites during this time period. Among the reasons cited for these differences are higher incidence rates and poorer post-diagnosis survival in part due to later detection. Despite these disparities, there are important indications of positive trends. Objective 16.11, which seeks to increase the proportion of women who have received a clinical breast exam and mammogram in the past 1 or 2 years, was 19 percent in 1987 for black women over age 50. In 1992, this had increased to 48 percent (see figure above). Also, the rate of cigarette smoking is lower among black teens and young adults than it is for the total population. In 1992, the smoking rates for 18–24-year-olds were 28.0 percent for total males, 16.2 percent for black males, 24.9 percent for total females, and 10.3 percent for black females. Among the strategies cited to improve cancer morbidity and mortality in blacks were the need to involve the family and the community, to take culture and lifestyle into account in the design of risk-reducing programs, to increase access to health care, and to encourage people to seek care early.

Coronary heart disease and stroke mortality have declined over the past decades, both for the total population and for blacks (objectives 15.1 and 15.2). Between 1987 and 1991, the age-adjusted death rate for heart disease per 100,000 decreased from 135 to 118 for the total population and from 168 to 156 for blacks. Thus, the challenge remains to meet the year 2000 target for blacks of 115 deaths per 100,000. Among the reasons for the remaining disparity between blacks and the total population is the higher prevalence of risk factors such as hypertension, obesity, and cigarette smoking, and decreased control of blood pressure and cholesterol levels. Potential strategies to reduce this gap include increased research and evaluation of programs to provide greater insight about what works, community-based (including worksites, schools, churches) education and intervention efforts, and the need for additional knowledge about the influences on health care-seeking behavior.

The progress review concluded with a summary of action items for pursuing HEALTHY PEOPLE 2000 objectives, with a focus on health promotion and disease prevention for black Americans. These involve efforts to strengthen prevention services, research, and educational activities. In services, followup items include improving consolidation and flexibility in grant programs to be better adapted to community needs, developing strategies to enhance the physical environment in communities, and developing a plan to broaden the reach towards young people. In research, this includes identifying strategies to strengthen the ties between academic institutions and communities, incorporating plans for increased effectiveness research, and developing a proposal to examine the special risk factors experienced by victims of violence. Educational efforts include summarizing successful community efforts, developing a media campaign with particular messages to target youth, and exploring how to broaden public health to address the relationship between social problems and health outcomes.

Mammogram in Past 1–2 Years, Women Age 50 and Over



Source: CDC/NCHS, National Health Interview Survey

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health Services Administration
Office of the Surgeon General

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